State of Arizona
"Protecting the Public's Health"
Naturopathic Physicians Medical Board
Janice K. Brewer, Governor **1400 W. Washington, Ste 300 Phoenix, AZ 85007**
Phone: (602) 542-8242 FAX: (602) 542-8804 www.aznd.gov

Application to <u>ENGAGE IN A PRECEPTORSHIP TRAINING PROGRAM Must include the following</u>

☐ **FOR INITIAL CERTIFICATE APPLICATION**

___ Money Order in the amount of **$100.00** payable to the AZND Board
___ Money Order in the amount of **$22.00** payable to DPS
___ Completed Fingerprint Card
___ One (1) passport-size photograph taken within the last 60 days with your signature on the back.
___ Citizenship /Alien Status Documentation Required State Law (A.R.S. § 1-501)

☐ **FOR RENEWAL OF CERTIFICATE**

___ Money Order in the amount of **$150.00** payable to the AZND Board

<u>APPLICANT INFORMATION</u>

Name of Applicant:_____

Applicant Address: _____

City: _____, **State**: _____ **Zip**: _____ **Phone**_____

Email Address:_____

Date of Birth: _____/_____/_____ **Social Security Number** _____/_____/_____ **Gender**: [ ] **Female** [ ] **Male**

<u>Citizen Status Declaration</u>: Are you a United States Citizen? **Yes____ No___** [INITIAL APPLICANTS]**Attach** a legible copy of the front and the back U.S. Passport, or U.S. Birth Certificate or State of Arizona issued Drivers License.

<u>If you answered NO to the, complete the question below</u>
Alien Status Declaration: Are you a legal resident authorized to work in the United States? Yes_____ No_____
Attach a legible copy of the front and the back (if any) of a document from the attached **List B** (available on www.aznd.gov) that evidences your status A.R.S. §1-501. Name of document provided_____

<u>MEDICAL COLLEGE INFORMATION</u> [INITIAL APPLICANTS]

Medical School from which you graduated: _____

Date Graduated::_____ **Transcript requested to be sent to AZND Board _____Yes, _____No**

<u>PRECEPTORSHIP INFORMATION</u>

Name of Facility:_____

Facility Address: _____
Number & Street City State Zip

SUPERVISING PHYSICIAN:_____

Medical License No._____

DESIGANTED SUPERVISING PHYSICIAN [IF APPLICABLE]:_____

Medical License No.:_____

CMO:_____ **Medical License o.:**_____

Answer the Following Questions

A.	Have you ever been charged with, arrested, convicted of, or entered into a plea of no contest to a felony or a misdemeanor?	[ ] Yes [ ] No
B.	Have you ever had a license/certificate, including a driver's license, suspended or revoked by any agency?	[ ] Yes [ ] No
C.	Have you ever been disciplined by any agency for any act of unprofessional conduct as defined in Arizona Revised Statutes, Section 32-1501?	[ ] Yes [ ] No
D.	In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation with a licensing agency?	[ ] Yes [ ] No
E.	Do you have a complaint pending before any agency?	[ ] Yes [ ] No
F.	Have you ever been found guilty of being medically incompetent?	[ ] Yes [ ] No
G.	Have you ever been a defendant in any malpractice matter that resulted in a settlement or judgment?	[ ] Yes [ ] No
H.	Do you have any medical condition that in any way impairs or limits your ability to practice medicine?	[ ] Yes [ ] No
I.	Do you currently have a complaint or open investigation in which you are involved?	[ ] Yes [ ] N

An applicant is required to submit a written supplement to this application if the answer is Yes to any of the above questions. ** The Fact that a conviction and/or criminal offense has been pardoned, expunged or dismissed, or that your civil rights have been restored does not mean that you can answer "No" to questions A through I.

I have READ and UNDERSTAND: 32-1561 and R4-18-108

Subscribed And Sworn To Before A Notary Public:

State of_____)

County of_____)

Print The Applicant's Full Name: _____ being first duly sworn upon his or her oath deposes and says all of the following: I am the person named in this application. I have read and understand the contents of this application. The information contained in this application is true and correct to the best of my ability and the information submitted is without fraud, deceit or misrepresentation. I hereby authorize any hospital, institution, organization, personal physician, past or present employer, past or present business or professional associate or any local, state, federal or foreign governmental agency to release any information to the State of Arizona in connection with my application and state that a photocopy of this authorization shall have the same effect as the original. I also authorize the State of Arizona Naturopathic Physicians Board of Medical Examiners, or its successor, to release any information submitted by me, upon request, to the public or to any licensing agency, or to any other person, when such request is required or permitted by Arizona Revised Statutes. I acknowledge that any falsification in my application is cause to deny my application or for the Naturopathic Physicians Board of Medical Examiners to hold a hearing to revoke any naturopathic medical student internship, preceptorship or preceptorship training registration that is issued to me by the Board. I authorize the Board to tape record any application interview that is conducted of myself in regards to this application.

Signature of Applicant: _____

Subscribed and sworn to before me this _____ day of _____, 200_____

Notary Public Signature _____

My Notary Commission expires _____

NOTARY NOT REQUIRED FOR RENEWALS

SUPERVISING PHYSICIAN'S VERIFICATION FORM
TO ALLOW A NATUROPATHIC MEDICAL STUDENT INTO A
PRECEPTORSHIP TRAINING PROGRAM IN NATUROPATHIC MEDICINE

VERIFICATION OF SUPERVISING PHYSICIAN

- I AGREE TO BE THE SUPERVISING PHYSICIAN IN CONNECTION WITH THE ABOVE LISTED TRAINING FACILITY.
- IN THE EVENT THAT I WITHDRAW FROM SUPERVISING, I WILL IMMEDIATELY NOTIFY THE BOARD.
- IN THE EVENT I AM NOT AVAILABLE AS SUPERVISING PHYSICIAN, THE FOLLOWING HAS BEEN ASSIGNED AS A DESIGNATED AGENT. [If Applicable]

Supervising Physician's Designated agent: _____

Designated Agent's Arizona Physician's License Number: _____

Address of Designated Agent: _____

City, State, Zip: _____

- **I HAVE READ AND UNDERSTAND** A.R.S. §**32-1561**. B. If the application submitted pursuant to subsection A of this section is approved by the board, that person may engage in a board approved internship program, clinical fellowship or **preceptorship** program under the **direct supervision** (***Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.*)** of a physician licensed under this chapter or by a physician licensed pursuant to chapter 13, 17 or 29 of this title. C. The board by rule may prescribe naturopathic medical treatment procedures that a person who is certified under this section may perform under the **direct supervision** (***Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible*.)** of a physician licensed under this chapter if the board determines that these procedures:1. May be competently performed by the graduate.2. Do not exceed the procedures that the supervising physician has been licensed by this state to perform. D. A person who is certified under this section may do clerical tasks without direct supervision if the tasks do not involve diagnosing or treating a patient's condition. E. If the supervising physician of a person who is certified under this section withdraws from direct supervision, the certificate to engage in the training program held by that person is automatically canceled. F. A person who is certified under this section shall not employ that person's supervising physician and shall not have any financial interest in any business owned by that person's supervising physician.

Furthermore I have **READ** and **UNDERSTAND R4-18-108** regarding the use of title An UNLICENSED graduate of a Board approved school of Naturopathic Medicine who is certified by the Board to engage in preceptorship training SHALL use the designation "(**PRECEPTEE**)"***after*** any of the following designations, Doctor of Naturopathic Medicine, N.M.D., Doctor of Naturopathy, N.D. Naturopath, Naturopathic Physician, or Naturopathic Medical Doctor. The PRECEPTEE SHALL also ensure that any patient treated by the preceptee **SIGNS AN INFORMED CONSENT TREATMENT FORM STATING CLEARLY THAT THE PRECEPTEE IS UNDERGOING TRAINING, IS NOT LICENSED, AND INDENTIFYING THE NAME OF THE SUPERVISING PHYSICIAN. THE PRECEPTEE MUST NOT IN ANY WAY LEAD THE PUBLIC TO BELIEVE THAT HE OR SHE IS A LICENSED NATUROPATHIC PHYSICIAN.**

Signature of Supervising Physician: _____Date_____